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EARL E. KLEINSCHMIDT, M.D.
Wooster, Ohio

Assistant Editors
GERTRUDE E. CROMWELL, R.N. Denver, Colorado
H. F. KILANDER, Ph.D. Washington, D. C.

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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XXIII NOVEMBER, 1953 No. 9

STATION KSLH's PROGRAM: KNOW YOURSELF

B. Y. GLASSBERG, M.D.
Lecturer on Personal and Family Living
St. Louis Board of Education

Many persons seriously interested in the welfare of the American people decry the increasing toll of mental illness. Others accept it as part of the price which must be paid for the dizzy pace at which we live. They take it as evidence of the human being's lack of capacity to react to the stress and strain, the anxiety and worry found in a world uncertainly geared to the atomic miracle. We here in St. Louis are hopeful that our program *"Know Yourself"* planned to aid the student to improve his management of his emotions may be somewhat helpful in reducing the incidence of mental instability, neuroses, and nervous breakdown.

The *Journal of School Health* has reported other efforts in this direction as they are carried on in other communities of the nation. Our own program stems from the following premises as to a basis for mental health:

1) The individual should hold a reasonably good opinion of himself as a human being endowed with certain special skills and capacities which he wants to develop through his own persistent effort;
2) The individual must learn to develop satisfying interpersonal relationships in each of the many groups of which he is a part;
3) The individual must learn to accept success with becoming humility, more importantly to see failure only as a challenge to renewed effort toward success in his own living.

Before Radio Station KSLH, owned and operated by the St. Louis Board of Education, went on the air in 1950 Dr. L. L. Tate, Director of the Division of Health and Hygiene, invited me to develop a program on mental health that would have meaning for children in the seventh and eighth grades. A discussion type program was developed for broadcast once each week during the school term. Technical problems in presentation and production were ironed out through the efforts of Miss Marguerite Fleming, Director of Station KSLH and her associates.

Preparing the Broadcast

The writer discusses with two boys and two girls from a seventh or eighth grade class in one of the St. Louis schools common occurrences in living. Associated problems are interpreted in simple psycho-dynamic terms with particular reference to the feelings of the individuals involved, the kinds of emotions which surged up and the physical actions thereby produced. If this led to a personally or socially undesirable action or reaction the group seeks to discover some other type of management which might have resulted in a more acceptable outcome.

The student is encouraged to "talk out" his feelings as a means of lessening the tensions aroused within him. He is encouraged to appreciate the importance of allowing other persons involved with him to talk out their feelings in order that the group may reach a mutually acceptable compromise. This pattern of action is sought even though the altercation involve adults as well as children, whether these adults be parents, teachers, or neighbors. Discussion is implemented by asking permissive questions such as, "What did you think," "How did you feel," "What did you want to do," "What did he want to do," "How do you think he felt," "What do you think made him do that?," etc.

For example, in a discussion on anger one of the students described an evening when an older brother threw his pet cat over the fence. The older brother was not angry at the younger child. He was mad at himself over a difficulty which had occurred at his employment. This dramatic incident offered a focal point from which the general subject of anger could be interpreted in the actual life experiences of the twelve year old audience hearing the program in their own class room.

Use of the Program

At the beginning of each term teachers of the seventh and eighth grades are offered a handbook listing the topics to be presented together with questions for which an answer will be sought in the broadcast. Some teachers discuss the subject with the class ahead of time, assigning specific students to open a post-broadcast discussion. Others write out the topic on the blackboard shortly before the broadcast hour. Still others make no special preparation but do seek to stimulate a general class room discussion in which all children are encouraged to relate their personal experiences and feelings.

The following quotations from a recent handbook indicate the central ideas which I seek to develop out of the recital of the panel-

ists who are without prior knowledge of the topic:

Program V: How Can You Get Rid of Tension?
Do You ever feel tense and nervous? Do normal people get nervous? Is it a sign of weakness? Of strength? Do you know what makes you nervous? Do you do anything about it? What happens to you if you don't get rid of your worries?

Program X: Can You Clear Your Mind for Thinking?
"To think" means to bring something before the mind. Is it hard or easy for you to think? What gets in the way of your thinking? Does worry interfere when you are trying to think? What do you do about it?

No effort is made to reach a definite conclusion. The matter is left open. Decisions are to be reached by the individual student out of his increased awareness of the human emotions involved as they pertain particularly to him in the light of his past experiences.

Those teachers who choose to use the program tune it in; no compulsion is placed upon any teacher to use it. The teacher is urged to use the broadcast material as a springboard upon which to base a general class room discussion completely permissive in type. The simple ventilation of emotional feelings may be beneficial. The opportunity for all children to hear the comments of their classmates may help them to understand and appreciate the universality of human experience. The give and take of free discussion may promote attitudes of empathy which do so much to facilitate human relationships. Above all, teachers are urged not to moralize or to seek to draw conclusions from the discussion either of the radio panelists or of the students in the class room.

Qualifications of Student Participants

As moderator of the program it is gratifying to draw attention to the solid wisdom possessed by so many of our students. They are motivated by a fine idealism. There is universal recognition of the meaning of friendships and a genuine desire to foster them to socially desirable ends. They appreciate the need for some type of social organization and manifest a willingness to find their places within it. They are well aware of the impact of early habit formation on adult living. They seek a reasonable kind of freedom from too close parental restraint, but are mindful of parental authority and the necessity of parental direction. They resent unreasonableness in adults at the same time that they are mindful of their own and others' dignity. They would accord each person a proper measure of personal recognition.

HYPEROPIA IN SCHOOL CHILDREN: ITS DETECTION WITH A PLUS SPHERE LENS AND ITS SIGNIFICANCE IN READING

LUCILLE JOHNSON, R.N.
Oakland, California

It is possible to find numerous reports on the use of a plus sphere lens for screening purposes as the plus sphere test is a part of the Massachusetts Vision Test, now being used in some areas. The developers of this test, the Massachusetts Department of Public Health, report by letter, that about 7 per cent of all school children will test farsighted when a 1.75 lens is used for young children and a 1.50 lens for older ones.

In Oakland, it was decided to begin screening with a plus 1.75 lens in addition to the Snellen test already employed. Table I which shows our average of 1.5 per cent also shows that in no age group did we come near to 7 per cent. This may be partially explained by the nurses' lack of confidence in an unfamiliar instrument. Some of the nurses reported they rechecked a youngster who had previously tested hyperopic and upon recheck found him not farsighted, whereupon he was not included among the farsighted. This is understandable before sending home a "referral" letter, but actually for screening purposes these children should have been counted. The inconsistency is probably due to the muscles of accommodation relaxing better on some occasions. It is, however, difficult to comprehend this factor as accounting for the difference of 5½ per cent.

In a study by Kempf, Jarman and Collins,[2] 1860 white school children were examined with a cycloplegic. Among all children 2.7 per cent had 1.75 diopters of hyperopia. In this study there was, of course, no opportunity for accommodation, so again it is difficult to comprehend the findings of 7 per cent with a plus sphere lens in a screening procedure where it is necessary for the student to relax his muscles of accommodation before he will test hyperopic.

TABLE I. FAILURE RATE FOR PLUS SPHERE VISION TEST BY GROUPS

Group	*Total Tested*	*Number Failed Plus Sphere*	*Percentage Failed Plus Sphere*
Grades One Through High Twelve	4,566	115	3.5
Grades Low Four Through High Six	7,166	104	1.4
Grades Low Seven Through High Nine	2,890	31	1.
Grades Low Ten Through High Twelve	2053	13	.63
Total	16,675	263	
Average			1.5

Actually there is some justification for not using a plus sphere lens for screening purposes: several textbooks on ophthalmology [1, 3, 4] say in effect that a child with up to two or three diopters of hyperopia may go without correction unless there are symptoms of visual impairment or fatigue. The nurses who did the screening here are aware that symptoms are as important as any screening. Also, if glasses are not going to be prescribed unless there are symptoms, then perhaps checking with a plus sphere lens every child who has 20/20 vision may be a superfluous procedure since generally each child is questioned to determine if he has symptoms of eyestrain or visual impairment.

TABLE II: THE SIGNIFICANCE OF THE DIFFERENCES BETWEEN PERCENTAGES OF GROUPS

Groups Compared	*Critical Ratio*
Grades 1, 2, 3, and 4, 5, 6	7.0
Grades 1, 2, 3 and 7, 8, 9	8.3
Grades 1, 2, 3 and 10, 11, 12	8.9
Grades 4, 5, 6 and 7, 8, 9	1.8
Grades 4, 5, 6 and 10, 11 ,12	3.7
Grades 7, 8, 9 and 10, 11, 12	1.5
Groups tested routinely and Groups tested specially	9.2

While the theory that the eyeball is too short and therefore is the cause of most hyperopia is not universally held, it is rather well accepted in medical circles.

In the study by Kempf, Jarman and Collins 63 per cent of the children were hyperopic. The majority of this group were retested 2½ years later and it was found that the degrees of hyperopia had decreased 20 per cent.

Table I shows that by groups, in this study there was a decreasing percentage among older children. Table II shows that the differences between these percentages are statistically significant. As would be expected from the theory that hyperopia is outgrown with increasing age, the differences are most significant between groups with the largest age differences between.

The grades tested routinely—that is, in entirety—were the High First, Low Third, Low Fourth, Low Fifth, Low Sixth, Low Eighth, and Low Tenth. Children from other grades were tested only for some special reason such as teachers' requests, students' complaints, prior to examination by the school physician, or new entrants to the school system. The first group had a failure rate with the plus sphere lens of 1.5 per cent and the second group 2.7 per cent. Table II shows that this difference is highly significant.

This difference can probably be explained by the number of children who were tested because of visual complaints and teachers' requests. These children reasonably are more frequently hyperopic than a similar group tested routinely. This again points to the value of teachers' observations as compared to routine testing.

Picking out reading disability cases is of only secondary importance since every child has a right to eye comfort even though through accommodation he incurs no reading disability.

While investigators certainly do not agree on the relationship of reading disabilities to vision defects in general, few, if any, report anything but a positive correlation between hyperopia and reading disability. This is, of course, stating only a relationship, not a cause, and it is possible the hyperopic child may have problems besides vision. The very young child is "normally" hyperopic. If this condition is present in an older child it suggests other immaturities. He may be immature mentally and emotionally. He may be socially dependent as well as physically immature. These conditions as much as his visual handicap may contribute to his difficulties in school.

Of 2,185 Low Fourth grade students vision tested here 36 were found by means of the plus sphere lens to be farsighted. Within the same semester 34 of these 36 had been given the Progressive Reading Test, Elementary, Form C, and the Kuhlmann-Anderson Group Mental Test Grade IV. The median chronological age of this group of 34 was 8 years and 11 months as compared to 9 years and 1 month for the group as a whole. There is apparently a tendency for farsighted children to be younger. It is possible that as a group they are hyperopic because they are younger.

This group of hyperopic children had a mean mental age of 8 months above that of the larger group. This difference is significant at the 1 per cent level. The possible explanation here is that because they are a younger group they are a brighter group and because they are a younger group they are hyperopic.

The mean reading age of this farsighted group was 1½ months below the Low Fourth as a whole. This is not a statistically significant difference, but may show a tendency to a handicap in reading.

However, if it is possible to assume that this group like the Low Fourth graders as a whole, should have a mean reading age of 4 months above their mean mental age then there is doubtless some definite factor characterizing this group since the critical ratio of

the difference between their *actual* reading age of 9 years and ½ month and their mental age of 9 years and 6 months is 3.2.

It appears that the instrument has a selectivity for younger, brighter children with a tendency to reading difficulties. Further study of this group would be enlightening. It would be advisable to determine after correction of the visual defects if their gains in reading were greater than for the rest of the students.

Summary and Conclusions: In general the findings in this study tend to bear out the theory that as the eyeball grows, hyperopia will decrease.

Our findings, however, do not show that about 7 per cent of all children will test hyperopic as was found by the developers of the Massachusetts Vision Test.

Further study is needed to determine whether or not too many are dismissed by doctors as having inconsequential defects.

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KENTUCKY SCHOOL SANITATION SURVEY *

Tin dippers and common drinking glasses were still in use in some rural schools in Kentucky early this year. They were discovered during a survey of water supplies, toilets and waste disposal facilities in 172 schools in 8 average counties there, according to an article in the June issue of the Kentucky *Plumbing and Heating Index.*

In this survey, made during the period January through April by state and local health department sanitarians, schools often were found to have no water supply. They depended on water carried from nearby houses, springs or streams. Many others had unsatisfactory wells. Where running water was available, fountains frequently were not of the approved angle type or lacked pressure. Water supplies were found to be in some way unsanitary in 90.1 per cent of the schools.

In respect to toilets and waste disposal, conditions were found to be equally unsatisfactory.

* Health Officer's News Digest, August, 1953. p. 17.

FUNCTIONAL HEART DISEASE*

MORSE J. SHAPIRO, M.D.
Chairman, PTA Heart Board

In recent years the public has become well aware of the fact that heart disease is the leading cause of death. Recent statistical surveys indicate that approximately one-half of our people eventually succumb to some type of heart disease. There has been considerable excitement and interest in the recent remarkable advance in the treatment of cardiac disease. This is especially true of surgical intervention for various types of birth defects of the heart as well as valvular heart disease. The availability of this information for public consumption is desirable because much can be done in the way of prevention if the public is well informed. However, this widespread publicity has caused a great many people to become heart conscious. Every time a newspaper article appears indicating that a prominent citizen has died suddenly of a heart attack, many people begin to complain of chest pain. Murmurs in the heart—frequently of no significance found on routine physical examination—often produce great apprehension. Many people have irregularities of the heart which are unimportant and are usually due to irritability of the heart. In this article, I should like to discuss what is labeled by the medical profession as "functional heart disease." By functional heart disease we mean a type of disorder which is not based on real organic disease and is of no significance.

Non-Pathological Murmurs

Not so many years ago, when a doctor heard a murmur in the heart, he made a diagnosis of valvular heart disease. Later it became known that many of these murmurs were unimportant and did not really indicate disease of the heart. For a period of time, most systolic murmurs were considered of no significance. Recently, however, experts in diseases of the heart have concluded that all murmurs are important and need to be evaluated. There are certain murmurs in the heart which are not indicative of heart disease and should not worry the patient. In order to differentiate between a so-called non-pathological murmur and one which indicates real heart disease, a complete study of the heart must be made. This usually includes a thorough history, a complete physical examination of the entire body, fluoroscopic and X-ray studies, as well as

*Reprinted from HEALTH EDUCATION JOURNAL, Los Angeles City Schools, February, 1953, by permission of Dr. Blanche Bobbitt, Editor.

electrocardiograms. In some instances, even more complicated X-ray and laboratory studies must be done before one can conclude whether or not a murmur is of any significance.

Murmurs are particularly common among children of school age. Many of these murmurs are caused by some peculiar course of the vessels in the neck producing what is known as a "venous hum." Some murmurs are frequently transmitted into the chest and often result in an erroneous diagnosis of organic heart disease. There are other murmurs which are heard in various locations over the heart and which are also of no importance. It is essential to leave the impression that merely because a murmur is found in the heart does not metn that the child or adult has organic heart disease. As has been stated above, only after careful study can a final, correct opinion be given as to the importance of any particular murmur.

Unimportant Irregularities of the Heart

Irregularities of the heart are not uncommon both in children and adults. A great many of these irregular rhythms occur in hearts that are diseased. However, extra beats, so-called extrasystoles, not infrequently occur in people who have otherwise normal hearts. These skipped beats occur in unusually nervous individuals. Many people have these irregular heart beats and are not conscious of them at all. Others are aware of each skipped beat and are made nervous and apprehensive by these irregularities. It is not uncommon to find these extra beats in children at an early age. In the study of such children over a period of many years until they have reached adulthood, it has been found that this same irregular beat was persistent but at no time was there any evidence of organic heart disease. Here again, in order to determine whether or not irregular heart beats are of any significance, a complete cardiac study is required.

Neurocirculatory Asthenia

Another condition which often leads to errors in diagnoses in children and in adults is one known as effort syndrome, soldier's heart, or neurocirculatory asthenia. Patients with this type of functional heart disease often complain of palpitation, pressure around the region of the heart, easy fatigue, and profuse perspiration. Such individuals are usually thin, underweight, and sensitive. These young people are often found to have murmurs over the heart. Their heart sounds are very rapid and their response to exercise poor. They frequently find it difficult to keep up with the

average child of their own age. When young men of this type are inducted into the army, they cannot keep up with the other men on the drill grounds. These people are certain they have serious heart disease because they are heart conscious due to the constant palpitation at the slightest exercise or emotional stimulation. On careful physical examination, it is found that they do not have organic disease. It is undoubtedly true that their rapid, irregular hearts are secondary to emotional instability. Some are born with a constitutional inferiority which results in emotional instability. Others develop this condition as a result of environmental difficulties.

There are too many people who live in fear of heart disease when, in fact, they have no organic disease of the heart at all. It is a serious matter for a child or a young adult to be told he has heart trouble when organic disease is not present. Not infrequently, such individuals go through life with a constant fear of dying from heart disease, even after they have been told as a result of careful examination by outstanding experts that they have no heart disease.

There are too many children who are being restricted in one form or another, are not permitted to take regular gymnasium or to compete in football, tennis, etc.—only because they have an unimportant murmur or an irregularity of the heart. There are also children who are attending special schools because of "heart disease" when, in fact, they have little evidence of organic disease of the heart. No child should be permitted to suffer the restrictions involved in attending a special school unless such attendance is absolutely necessary. Most children with real organic heart disease can attend regular school. In some instances, it may be necessary to make special provision for them.

As one who was a pioneer in the development of special clinics and special schools for children with disease of the heart, I now have considerable doubt as to whether or not any special schools are needed for such children. This belief is also true of children who are said to be bedridden or housebound because of heart disease. Before a child is permitted to have a home teacher, and not allowed to attend his own school and play with the children of his own neighborhood, one must be certain that such special care is absolutely necessary. Serious consideration must be given to the morale of a child and to what will happen to him in future life if he is kept from his own childhood playmates and led to believe that he has serious heart disease, when, in fact, he has no organic disease or minimal heart disease which requires no treatment.

The fear of heart disease is a dreadful thing. But it is also

good to know that the general public is becoming aware of the newer treatment of cardiac disease. However, in our desire to inform the mass of our people, let us not be responsible for the development of many cardiac neurotics who really suffer for years because of imaginary disease of the heart.

* * * * *

MORE SOAP AND WATER

JENS DAVID HENRIKSEN, M.D.

Use more soap and water than you ever have used before.

Many people think that access to hot water and a bathroom is necessary in the best care of the skin. However, nothing is more strengthening and cleansing than cold water. Once accustomed to a cold morning bath, you will find that there is no better tonic than a vigorous rubbing with a friction mitt in cold water. The sense of well-being you have from this rubdown is due to the pronounced universal dilatation of the blood vessels in the skin. In turn, the blood vessels transmit the tonic to your heart action and your breathing. You will notice a decided reddening of your skin, and all your tiredness and fretfulness vanish. The blood supply to your brain is more brisk, and you can think and work more efficiently.

Want to get rid of a poor appetite and sluggish digestion? Try the cold bath with friction afterward. The natural stimulation of your skin will be transferred to your inner nerves, and within a short while you will be enjoying an ample breakfast. You may be able to say good-by to constipation as well.

Your skin is an essential organ. It is a protection against temperature extremes, a vital part of the entire sensitive function of your nerves, a regulator through its innumerable sweat and oil glands, and a wall against body contamination.

You must take special care of your skin so that its functions go on smoothly. Your efforts will be rewarded by greater vitality, vigor, and resistance to surrounding conditions.

Proper care of the normal skin includes the use of soap and water daily, sun baths in summer, artificial sun baths in winter, correct clothing, and regular exercise to stimulate the glands of the skin.

Build up your health yourself through improved daily care of your skin.—*Life and Health.*

SCHOOL CARDIAC CENSUS — 1953

JACOB M. CAHAN, M.D.
Philadelphia, Pa.

The incidence of heart disease in children of school age in the city of Philadelphia was first reported in 1929[1], and was based upon a survey of 10,333 children from ten public schools. The present report, based upon a census taken in mid-February, 1953, includes pupils of all the 233 public schools. It does not include children who are not on school roll or children belonging to parochial and private schools. Several similar studies have been reported from other cities, [2, 3, 4, 5].

Statistical Data and Background of Census

Philadelphia is a city with a population of 2,071,605 (census 1950). The "School Health Act" of 1945 provides for a complete medical examination biennially. This law gives blanket permission to remove sufficient clothing to insure a complete physical examination of the child. Furthermore, Rheumatic Fever has been a reportable disease in the city since April, 1945.

The 1953 Statistical Report of Philadelphia Public Schools presents an overall picture of the pupil population in the city. The city has 374,406 children, ages five to seventeen. This number includes all children enrolled in all schools of the city. It also includes children who were not enrolled in any school because they were legally employed (7,191) or not employed (25,794). The pupil enrollment consisted of 215,641 in public schools, 112,620 in parochial schools, and 12,980 in private schools. As stated above, this census covers all public school children but does not include children who attend parochial and private schools, or are not on roll.

From Division of Medical Services, School District of Philadelphia, Ruth H. Weaver, M.D., Director.

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School children are generally of ages five to seventeen. There is considerable overlapping of the range of children's ages in all schools. Thus the statistical city report lists the pupils' ages from four to twenty. It is noteworthy that the school considers a pupil's given age until the very day of next birthday. For example, a child is seventeen even one day before his eighteenth birthday.

Method and Material

As previously mentioned, the Commonwealth of Pennsylvania requires a biennial complete physical examination of each school child. This is done while the pupil is in uneven grades (1,3,5,7,9, 11). A brief medical history followed by a routine general physical examination is the first step in screening for cardiac reexamination. Children were considered as candidates for cardiac consultation if they had any of the following: a history of rheumatic fever or chorea, actual or questionable organic heart disease, hypertension, tachycardia, most of those who have so-called "functional murmurs" or a gymnasium excuse for any heart condition, and any abnormality of the cardiac contour reported on x-ray study. This first cardiac consultation was done in the schools or in the Heart Station of the School Administration Building. Limited laboratory blood studies and electrocardiography were done in the Heart Station, and, when indicated, fluoroscopic and orthodiagraphic examinations were made at the Jefferson Hospital. The consultation is recorded on a special cardiac form that provides space for the history, signs discovered on physical examination, and laboratory tests, complete diagnosis, recommendation and subsequent follow-up entries. In the majority of cases, diagnoses were based on the clinical opinion of the cardiologist. The criteria for diagnosis were in accordance with the "Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels by the Criteria Committee of the New York Heart Association."

In the course of processing cardiac reports from private physicians, all entries were carefully scrutinized as to history, physical examination, diagnosis, and recommendation. We accepted the diagnosis if a physician's diagnosis was "No Heart Disease" or there was a history of rheumatic fever, or rheumatic or congenital undiagnosed manifestations, and there was no entry of cardiac enlargement, diastolic murmur or other finding suspicious of organic lesion. However, all cases with a diagnosis of organic heart disease were reviewed more critically and the diag-

nosis was verified or revised. The child was reexamined by a consultant unless the original diagnosis was made by a cardiologist. Puzzling cases were sometimes jointly re-evaluated by two consultants, or referred to various hospitals for more elaborate instrumental diagnostic procedures.

School physicians and nurses have been referring heart suspects for diagnosis for over a quarter of a century. The special cardiac form was instituted in 1945. Since September, 1945, every public school has had the cardiac consultant go over the listed heart suspects in the school at least once. Many schools have had the consultant two or three times, and hundreds of children have been reexamined numerous times at annual or other intervals. The master file contains over 19,000 names.

For the purpose of this census each child's school medical record was reviewed. Only organic heart cases were included. Congenital anomalies, acquired lesions, and any combination of both, were listed separately. Thirteen combined congenital and acquired cases have been included with the congenital anomalies.

The enrollment, the general average age distribution of pupils in elementary and secondary schools, the number of school units, and the number and percentage of organic heart cases are shown in tabular form.

Since the pupil receives the first complete physical examination while he is in the first grade, the 12,942 kindergarten children are not included in the census of enrollment and heart cases. Numerous kindergarten and pre-school children have been given examinations, but these as well as entire rheumatic families, have not been included in the school census if they were not on the school roll in February, 1953.

Pupils who were absent from school for three successive months or over are termed chronic absentees. They may be at home, in hospitals, or in convalescent homes. Twenty-two organic heart cases were found among the chronic absentees in homes, various hospitals, or convalescent homes. An additional thirty-two cases were having visiting home teachers, and forty such cardiacs—all with acquired lesions—were in the Children's Heart Hospital,—a total of 94 heart cases among chronic absentees.

A breakdown as to sex and race was not feasible at the time. It may be noted though that the general school population consisted of 50.7% boys and 49.3% girls of which 67.3% were white, 32.6% were negroes, and 1% other than white or negro.

Table of Enrollment and Organic Heart Cases
Philadelphia Public Schools, February, 1953

	Elementary Schools and Special Classes	Junior High Schools	Senior High and Vocational Technical Schools	Total
Enrollment*	129886	38193	39383	207462
Age group, years	5 to 11	12 to 14	15 to 17	233
Number of school units	189	24	20**	393
A. Congenital Heart Anomaly				
Number of cases	247	77	69	.2
Percent of enrollment	.2	.2	.2	
Percent of total heart cases due to congenital heart anomalies	35.29	24.29	24.91	30.37
B Acquired Heart Disease				
Number of cases	453	240	208	901
Percent of enrollment	.34	.62	.52	.43
Percent of total heart cases due to acquired heart disease	64.71	75.71	75.09	69.63
Total Heart Cases (congenital and acquired)				
Number of cases	700	317	277	1294
Percent of enrollment	.53	.82	.7	.62

* Does not include kindergarten children.
** Two units are combined junior-senior high schools.

Comparison of the Survey and of 1929 and This Census

What is the incidence of heart disease in school children, and what is the relative proportion of congenital to acquired at present? The areas in which the ten schools of the 1929 survey were located had populations whose means were moderate as well as some children from families whose economic situations were better. In this respect, the first survey reflected a comparable group of the entire 1953 public school population enrolled in all the

schools that drew from all parts of the city. A comparison of these two surveys seems to show a decline in the general incidence of heart disease and a relatively higher proportion of congenital to acquired cases. A higher relative proportion of congenital to acquired cases may be due to a higher incidence of detection of congenital anomalies coupled with a diminished incidence of acquired heart disease. Probable contributory factors in the apparent decrease in the incidence of heart disease in school children are research, professional and public education in the prophylaxis of heart disease, improved general standards of living, with avoidance of such aggravating epidemiologic factors as poor housing and exposure to dampness, improved general therapy—medical and surgical, early and adequate treatment of children who have streptococcal infection and the use of sulfonamides and antibiotics. Perhaps our conservative attitude to organic heart disease and improved diagnostic aids, also contribute to the possible reduction of incidence. Still another factor may be the exclusion from consultation of many children whose cardiac murmur at first seemed to be insignificant. Yet every cardiac consultant has discovered some organic cardiacs among children with so-called "functional murmurs." Many such revised diagnoses were made by the same cardiologist who at one time was under the impression that the murmur was insignificant. It is hoped that physicians had not overlooked organic heart disease just because there was a "functional murmur." If the reduced incidence is a true reflection of the general situation, it is so at a time when the population is even more heart conscious than it was before.

A 1953 census of organic heart disease in children of school age is reported. Statistical data are presented. The background of the census and factors affecting the incidence of heart disease are discussed. Comparison is made between the surveys of 1929 and 1953.

* * * * *

IT'S THE MILK NOT THE CEREAL

It is unfortunate that some have seized upon the results displayed in recent literature to claim nutritional superiority of one cereal over certain others. This practice is unwarranted, unethical, and not in the interests of the public good. Breakfast cereals are eaten with milk, only rarely with water alone. Any differences in the biologic value of their proteins is obliterated when consumed with the proper proportions of milk—a weight ratio of 1:1. *The Journal of Clinical Nutrition.*

ABSTRACTS AND REVIEWS

Pathogenic Potentialities of Domestic Water Fluoridation.—In 1930 it was established by biochemists in Arizona that fluorine in the water of the regions where "mottled" teeth are prevalent was responsible for this condition. The discovery that the incidence of tooth decay was also low in regions with relatively high fluorine content in the drinking water quickly led to the assumption that the natural fluorine content of the local water supply was the beneficial agent. Little attention was given to the possible favorable effect of sunlight, to the superior mineral content of foods, or to the fact that these regions produced citrus fruit with its high content of vitamin C. The precipitous conclusion regarding the relation of fluorine to dental health led to agitation for fluoridation of domestic water supplies, with the result that some 20 million Americans are compelled to partake of this medicated beverage irrespective of its possible long-term delecterious effects. The author directs attention to the strong affinity of fluorosis for calcium, which makes it unite with the calcium of teeth and bones. The ingestion of vegetable and animal food from areas with high fluorine concentration has resulted in the cumulative deposition of this element in the bones and teeth of man and animals. Subjects who have been using naturally fluoridated water for several decades have considerable periodontal disease, with enlargement of the roots and narrowing of closure of root canals and pulp chambers; premature aging of the tooth structure is promoted and extraction is made very difficult, with tendencies to root fracture. Many of these patients have severe gingivitis and pyorrhea. Workers in cryolite mining, who inhale fluorine dust, exhibit not only the aforementioned dental defects but also osteophyte formations on bones, osteosclerosis, calcification of tendons, "poker backs," and fixation of the thoracic wall. These same effects have long been noted in parts of Africa and India where the natives have long been using naturally fluoridated water. The author offers suggestions for protection against the toxic effects of fluorine for those who find themselves unwilling subjects of this experiment in mass medication. 1. He recommends the daily ingestion of small doses (5 to 10 grains [0.3 to 0.6 gm]) of certain innocuous calcium salts; calcium ascorbate is particularly valuable, since it also releases vitamin C. 2. An optional intake of foods rich in calcium is desirable, such as milk products and green salad vegetables. 3. An optional intake of citrus fruits will provide natural vitamin C to help counteract the toxic fluoride. (*Journal A.M.A., Aug.* 22, 1953, *p.* 1663.)

State Aid Supports Special Classes For Mentally Retarded.—A total of 93,315 mentally retarded children in Minnesota have benefited from a pioneer program launched in 1915 when the state legislature first authoried state aid to school districts for special classes for deaf, blind, and mentally retarded children, and for speech correction classes. Classes for crippled children were added in 1921.

Growth of what has become an accepted part of public education in this state is reflected in the fact that the special class program now represents a million dollar annual investment in Minnesota's handicapped children. Of state aid given for all types of special classes and instruction, that for the mentally retarded is the largest single item in the budget. Total expense, exclusive of pupil transportation, came to $657,519.61 for 1951-52. School districts received $412,059.60 in state aid. When state aid first became available, eight school districts employed a total of 25 teachers who taught 286 children. In 1951-52, school bells rang in 25 school districts for 2,357 mentally retarded children of school age.

The state board of education is responsible for the establishment of regulations for the conduct of special classes for which state aid is given. Mayme J. Schow is state supervisor of special classes for handicapped children.

Of the 144 teachers in the program, 102 are in the three largest cities, Minneapolis, St. Paul, and Duluth. They teach a total of 1,834 children. The remainder of the classes are in the smaller urban areas where 42 teachers are in charge of classes for 523 children.

Under the state's program of special classes for the mentally retarded, children whose intelligence is too low to enable them successfully to compete with normal children are given an opportunity to develop their individual skills and abilities through individualized instruction. To the extent possible, children in special classes are with normal children. The goals of education for handicapped children are the same as those for all children. The difference lies in the means or technics by which those goals can be achieved.

It is this approach that has made the Minnesota program one of the outstanding ones in the country. Wherever possible, handicapped children are taught in regular classes with normal children to provide them with a maximum opportunity for social development. A basic philosophy is that in most cases, handicapped children have far more ability than disability.

The program includes four experimental classes for children with intelligence quotients of minus 50. Communities where experimental classes are now in operation include Minneapolis, South St. Paul, Pipestone, and Austin.

At the secondary school level, a pattern for special class education is being developed at Vocational high school, Minneapolis. In 1951-52, 55 students spent half their time in a shop of their choice in classes with children of normal intelligence. The rest of the day was devoted to social studies, practical English, and practical arithmetic taught by two special class teachers. At the end of the four-year course, those who successfully complete the work will receive a diploma.

State aid for mentally retarded children may not exceed $240 per child. Reimbursement aid not to exceed $160 per pupil transported or boarded for mentally retarded children who are not able to travel alone to and from school without guidance and direction and who are enrolled in an approved special class is also allowed by the state.

Minimum enrollment in a class for the mentally retarded is five. Maximum enrollment is 15, with the exception of schools employing three or more teachers of mentally retarded children. In those cases, approval may be given for 18 pupils per teacher when acceptable provision is made for pupil instruction in homogenes. —*From Mental Health Progress.*

* * * * *

Living With a Disability. *Howard A. Rusk, M.D., and Eugene J. Taylor, in Collaboration with Muriel Zimmerman, O.T. R.,* and *Julia Hudson, M.S.* This text — profusely illustrated — shows numerous devices whereby the seriously physically handicapped person can do many things for himself which otherwise he would find it impossible to tdo.

The devices ranging from aid in dressing oneself, wheel chair facilities, toilet helps, and kitchen aids.—*C. H. Keene, M.D.*

* * * * *

Improving the Child's Speech. *Virgil A. Anderson,* Oxford University Press, New York. 333 pp. Price $5.50.

This is basically a text for the classroom teacher, but also should be helpful to physicians and parents.

Emphasizing the fact that speech improvement is an educational problem, it discusses the nature and development of speech, the recognition of speech disabilities, and the various types of speech disorders, and advises procedures for correction.—*C. H. Keene, M.D.*

Can You Blame Them?—Many voluntary hospitals are complaining about the shortage of nurses. Nurses trained in these hospitals are being siphoned away by veterans hospitals because of the attractive salaries offered by the latter institutions.

The statistics below reveal the wide difference between the salaries paid in voluntary hospitals and those paid in veterans hospitals. The Massachusetts State Nursing Association at its annual meeting in October, 1951, recommended the following minimum annual salary scale:

General Staff Duty Nurses	$2400 to $2600
Assistant Head Nurse	$2520 to $2760
Head Nurse	$2640 to $2880
Assistant Instructor and Training Supervisor	$2640 to $2880
Supervisor	$2880 to $3240
Instructor and Clinical Teaching Supervisor	$3000 to $3600
Assistant Director and Teaching Supervisor	$4200 to .....
Director	Salary open

The veterans hospitals, on the other hand, offer the following annual pay schedule:

Junior Grade	$3740 to $4540
Associate Grade	$4400 to $5200
Full Grade	$5060 to $5810
Senior Grade	$5940 to $6940
Assistant Director Grade	$7048 to $8040

Salary deductions in the voluntary hospitals are for:

Federal Income Tax
Social Security (1½% of salary)
Subsistence if furnished

In the veterans hospitals, salary deductions are for:

Federal Income Tax
Retirement Fund (6% of salary)
Subsistence

The veterans hospitals offer a 40-hour week, two days consecutively off per week, a vacation period of 30 days per year, and sick leave of 15 days per year.

On the other hand, the voluntary hospitals allow a 40-hour week, with 1¼ days of vacation per month, and 15 days sick leave per year.

Nurses can't be blamed for choosing work in veterans hospitals.* From *Norfolk Medical News*, January, 1953, p. 62.

* Standards set for nurses in voluntary hospitals are ridiculous. Their services are certainly as valuable as those of school teachers, whose minimum often is higher, and duties less strenuous. C.H.K.

* * * * *

Individual and Community Health. *William H. Stiles, M.D., M.P.H.* The Blakeston Company, New York, 1953. 492 pp. Price $6.00.

This is an excellent text.

More technical and descriptive than most texts issued under similar titles, it is written clearly and understandingly, and thus is well within the understanding of the average college student, if he really wishes to learn.

Its contents has the usual scope — accidents, infections, diseases and their control. Then follow chapters on nutrition, food sanitation, fecal-borne diseases, and the usual chapters on diseases spread by various agents, diseases related to environment and occupation. Socio-sexual facts and problems and maternal and child care get better presentation than usual. The disorders of the nervous system and the problems relating to medical care are explained.

This is a much worthwhile effort to extend medical and health knowledge to the college age group, and to develop proper attitudes toward oneself and one's environment, and to establish "the scientific emotional and social well-being."—*C. H. Keene.*

* * * * *

Physiology of Muscular Activity. *Peter V. Karpovich, M.P.E., M.D.*, W. B. Saunders, Company, Philadelphia, 1953. 340 pp.

This is the Fourth Edition of a well known and much used text originally by Edward C. Schneider.

Most of the text has been revised and rewritten. Chapters on Nerve Control, of Muscular Activity, and Energy Cost of Various Activities have been added. New topics discuss the effect of hypnotism on muscular activity, Reaction Time, Energy Cost of Weight Lifting, Skiing, at Load Carrying, etc.

Of particular usefulness are the chapters on Fatigue and Staleness, and on Tests of Physical Fitness.

An "inside of cover" list of Units of Measurements will find ready acceptance and use.—*C. H. Keene.*

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EDITORIALS

N.T.A. Launches 47th Annual Xmas Seal Sale

The forty-seventh annual Xmas Seal Sale opens this year on November 16 and continues through December. Each year the National Tuberculosis Association and its affiliates state and county associations remind us at this time that the dread killer, the tubercle bacillus, is still in our midst and that program aimed at prevention and control of tuberculosis is essential to our security. Few people, however, read beyond the headlines, unless perchance this disease has affected a member of their immediate family.

In an age when "miracle" drugs have become commonplace, it is difficult for the average person to appreciate the factors underlying the tuberculosis movement or the reasons for continuing the fight each year against this widespread scourge of mankind. The average citizen is inclined to shrug his shoulders at the suggestion that this "fight" is his fight. By and large tuberculosis associations have done a magnificent job of keeping this program alive and before the public. But, we occasionally see evidence in the press that some members of society are inclined to slacken

in their enthusiasm for the program that is being conducted throughout the United States.

In 1904, when the National Tuberculosis Association was founded, tuberculosis was the major health problem, the first cause of death in this country. Since then the death rate has been reduced 90 per cent. Tuberculosis is now the sixth cause of death. This, in itself, should be cause for exultation. But, it should also serve to remind people that the job is far from done. It is much more costly to find tuberculosis today than it was in 1904.

The "fight" against tuberculosis is not won by any means despite careless talk by some members of society that newer drugs have it "on the run!" Astounding as it may seem tuberculosis kills approximately 20,000 persons 45 years of age or over and 1,600 children under 15 in a single year!

Children today are just as vulnerable to the tubercle bacillus as in the past. There can be no let-up in the collective efforts of schools, health departments, tuberculosis associations and medical profession to place primary emphasis on prevention of this disease and its early detection with the use of those excellent weapons which medical science has made available to us. Tuberculin testing of school children is still the best means available to us for detection of the disease in its incipiency. Use of the X-ray in children over 14 years of age yields excellent returns for the investment made, despite the claims of certain vociferous members of the medical profession that vaccination with the use of B.C.G. is the answer to the tuberculosis problem. B.C.G. has had its "day in court," and as yet, there is very little evidence to support the contention of its ardent advocates. Objective statistical evidence is entirely lacking to substantiate its use, wherever it has been tried. The great progress that has been made over the past 47 years has been made as a result of tuberculin-testing, X-ray programs, and periodic examinations of persons in the susceptible age groups.

To the uninformed a case of tuberculosis is just an unfortunate person who, through ill-fortune, has contracted a chronic disease and must be sent to a sanatorium for treatment. The economic and social aspects of tuberculosis seldom gives the lay person cause for thought, unless the victim happens to be a member of his immediate family. A case of tuberculosis means on the average a cost of $14,000 to $15,000 to society. This figure includes medical care, compensation, loss of wages, pensions, and relief payments to the patient's family while he is incapacitated.

The very best ammunition that a local tuberculosis association can bring to bear at this time of the year to "sell" the public on tuberculosis prevention and control are facts,—cold, blunt facts as they affect the man on the street. Offhand, this might seem like wasted effort—assembling statistical facts bearing on this disease. But, it never fails to have its effect—if a skilled editor or journalist can weave them into a thought provoking editorial. Here is a task that a school health deparment could carry on to advantage. The schools, the local health department, the local newspaper, the radio station — all of these agencies have a job to do in getting the message of the Xmas Seal before the public. The local tuberculosis association deserves their unqualified support in making the continuance of this movement possible. —*E.E.K.*

* * * * *

Tooth Decay and Sugar

The action of the American Dental Association at its recent annual meeting in Cleveland in condemning the extensive use of sugar and candies is to be commended. The delegates to the convention, representing some 70,000 dentists, urged that all persons voluntarily restrict the consumption of sugar products on the basis that "convincing evidence has been accumulated over many years concerning the hazards to dental health resulting from the consumption of sugar."

The Association's House of Delegates recommended that the sale of sweentened drinks and candy be banned in schools. This may shock some of the staid members of the teaching fraternity who have promoted sales of candies so that high school graduating classes could make a pilgrimage to Washington, but it will give comfort to school physicians and nurses who have been advocating such a course of action for many years!

An editorial in the October issue of the Journal of the American Dental Association accused the producers of sweetened drinks of using unethical tactics in advertising that soft drink consumption does not contribute to dental decay.

The text of a resolution adopted by the American Dental Association House of Delegates follows:

> *Whereas,* convincing evidence has been accumulated over many years concerning the hazards to dental health resulting from the consumption of sugar, and
>
> *Whereas,* dentists have been bringing this evidence to the attention of their patients and the general public, and

Whereas, the Council on Foods and Nutrition of the American Medical Association has reported that sugar in the diet too frequently becomes a substitute for foods of higher nutritive value, and

Whereas, it is the responsibility of the health professions to recommend desirable dietary habits, and

Whereas, these recommendations have been challenged in the advertising of products, such as sweetened drinks and confections, that contain large amounts of sugar, and

Whereas, a recent report adopted by the Council on Dental Health and the Council on Dental Therapeutics provides a comprehensive review of the published evidence of the dental hazards of high levels of sugar consumption, therefore, in the interest of public health, be it

Resolved, that the Association recommend voluntary restriction in the consumption of sweetened beverages and confections, and be it further

Resolved, that the Association recommend that dental societies call to the attention of school administrators the need for eliminating from the schools the sale of sweetened beverages and confections, and be it further

Resolved, that the Association emphasize the responsibility of the manufacturers of sweetened beverages and confections for devising suitable methods to eliminate the dental health hazards associated with the consumption of their products.

This action by the American Dental Association should have far-reaching effects. Let us hope that parents and teachers will heed this timely warning. School health workers will do well to carry this message to every school district in the United States.—*E.E.K.*

* * * * *

"Health Teaching in Schools.—For Teachers in Elementary and Secondary Schools," 2nd edition, Ruth Grout, M.P.H., Ph.D., W. B. Saunders Company, Philadelphia, 1953. 353 p.

This second edition is an outstanding text designed for the information of teachers in training and teachers in service.

While broad in scope, it is sufficiently condensed to be within the time limit of the usual school health education classes. Numerous illustrations, drawn from widely scattered geographical areas, create interest and help to show the wide spread of the health education effort.

The chapters are ended with Summaries and Selected Reading —the latter designed to give the user intensive and extensive supplementary information regarding basic material.—*C. H. Keene.*

FOURTH NATIONAL CONFERENCE ON HEALTH IN COLLEGE

The Fourth National Conference on Health in Colleges will be held May 5-8, 1954, in the Hotel Statler, New York, N. Y. The Conference objectives will be: (1) To consider ways for protecting and improving the health of college students through comprehensive and integrated programs of health service and health education; (2) to formulate suggestions for relating college health programs to all other college functions. Participants will include college administrators, deans, directors of student health services, physicians, nurses, health educators, physical educators, and students. Dr. J. L. Morrill, President of the University of Minnesota, is serving as President of the Conference. Members of the Executive Committee are as follows:

Dana L. Farnsworth, M.D., *Chairman*
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Carl R. Wise, M.D., *Chairman*, Committee on Local Arrangements

* * * * *

Effect of TV on Children.—In a recent study of pupils attending schools in Dover, Ohio, reported in *The News Letter* of the Bureau of Educational Research of Ohio State University there appear to be indications that television is responsible for robbing children of needed sleep and creating eye discomfort. First choice of programs of primary and intermediate grades were Westerns. First choice of junior and senior high students was variety shows. More than two-thirds of the parents of primary children guide them in their choice of types of programs. One third of the parents of junior high pupils guide them. No adult guidance was reported for high school students. Of the kindergarten and primary grade children, 34 per cent said that TV makes their eyes hurt, burn or itch; 31 per cent of the intermediate-grade pupils so indicated; and 8 per cent of the high school pupils indicated eye discomfort.—The Sight-Saving Review.